Multidimensional Family Therapy

Program developers or their agents provided the Model Program information below.

BRIEF DESCRIPTION

Multidimensional Family Therapy (MDFT) is a comprehensive and flexible family-based program for substance-abusing adolescents or those at high risk for substance use and other problem behaviors. MDFT interventions target the research-derived risk factors and processes that have created and perpetuate substance use and related problems such as conduct disorder and delinquency. MDFT also intervenes systematically to help individuals and families develop empirically derived protective and healing factors and processes that offset substance use and behavioral problems. MDFT is a multicomponent and multilevel intervention system. It assesses and intervenes multisystemically with the:

- Adolescent and parent(s) individually
- Family as an interacting system
- Individuals in the family relative to their interactions with influential social systems that impact the adolescent's development

Interventions are solution-focused and strive to obtain immediate and practical outcomes in the most important individual and transactional domains of the adolescent's everyday life—home and school.

MDFT studies have been conducted at numerous geographic locales. It has demonstrated the capacity to significantly reduce substance abuse and behavior problems and improve school, peer, and family functioning in many different youth populations, including:

- Males and females
- Youth in urban, suburban, and rural areas
- African-American, Hispanic/Latino, and White youth between the ages of 11 and 18
- Youth with dual diagnoses
- Youth diagnosed with substance use only

- At-risk youth
- Youth who are adjudicated, diverted, and never involved with the juvenile justice system
- Families from various socioeconomic backgrounds

RECOGNITION

Substance Abuse and Mental Health Services Administration, U.S.Department of Health and Human Services (2005): Model Program

Channing Bete Co., *Communities That Care* (2004): Model Program

Drug Strategies (2003): Model Program

National Institute on Drug Abuse (2001): Effective Drug Abuse Treatment Approach

U.S. Department of Health and Human Services (2002): Best Practice

National Institute on Drug Abuse (1999): Science-Based Program

Office of Juvenile Justice and Delinquency Prevention, U.S. Department of Justice (1999): Exemplary Program

IOM CLASSIFICATION

SELECTIVE, INDICATED

Empirical data exists to support MDFT's use with both selective and indicated populations.

INTERVENTION TYPE

THERAPY

MDFT is a community-based and home-based therapy that addresses the youth's everyday environment: self, family, school, peers, and neighborhood in order to eliminate or significantly reduce drug use and provide alternatives to the drug-using lifestyle.

CONTENT FOCUS

ALCOHOL USE/ABUSE, ANTISOCIAL/AGGRESSIVE BEHAVIOR, ILLEGAL DRUGS, SOCIAL AND EMOTIONAL COMPETENCE

Parents as a primary population:

As an integral part of adolescents' lives, parents are integral to MDFT and instrumental to the program's therapeutic goals and methods. Parents' well being, in addition to their parenting and caregiving behaviors, is a core focus in MDFT. Consequently, parents' drug and alcohol use/abuse also are a program focus.

MDFT studies have demonstrated a relationship between changes in parents' well being and changes in their parenting practices and the clinical changes achieved in MDFT youth—decreases in substance use and delinquency and increases in family functioning, positive attitudes, and supportiveness (developmentally normative behaviors) in the daily family

environment. Thus, changes in parenting practices are key to changes in the youth's problem behavior. Youth behaviors and parenting practices are accessed through changes in the parents' well being (psychological functioning, stress and coping, social support, perception of role, and ability as a parent). In MDFT, parents and youth are assessed and treated simultaneously. Youth receive attention in individual and family sessions, as well as with extra-familial sources of influence—for instance, school or the juvenile justice system (if applicable) are immediately included in the intervention.

INTERVENTIONS BY DOMAIN

INDIVIDUAL, PEER, FAMILY, SCHOOL, COMMUNITY

INDIVIDUAL

Individual sessions focus on youth's current difficulties in school, in family, legal problems, and relationships problems. Motivation is enhanced, and skills are taught and practiced.

PEER

The youth's peer network is accessed through the treatment youth; the youth then is helped to address the nonadaptive nature of relationships with drug-using and delinquent peers.

FAMILY

Family sessions, sessions with parents, and sessions with the youth alone focus on everyday events in the family, particularly family relationships and their improvement. Past, important events are explored and addressed to the extent that they still create family relationship problems.

SCHOOL

Therapists go to the school with the youth and parent, sometimes acting as a mediator, advocate, or broker, to create new opportunities for the youth in the school or to create opportunities for the youth in a new or different school environment.

COMMUNITY

Therapists help families to be more vigilant about the dangers existing or the resources available to them within their local community.

KEY PROGRAM APPROACHES/COMPONENTS

COMMUNITY SERVICE, PARENT TRAINING, SCHOOL/COMMUNITY COLLABORATION, SKILL DEVELOPMENT, SUBSTANCE ABUSE PREVENTION EDUCATION, THERAPY, OTHER

COMMUNITY SERVICE

The therapist works closely with probation officers, court officials, or parents to use community service as a tool to promote healthy behaviors. The therapist will seek to place the adolescent in an appropriate community service location to match the skill that is needed for the adolescent to develop healthy behaviors. The therapist looks for a setting that the adolescent will enjoy and that will promote success.

COMMUNITY COLLABORATION

The therapist works closely with community agencies to create a strong support system. These community agencies can also be used to provide opportunities for adolescents and parents to learn important skills that will help them become successful and get their lives back on track. The therapist uses specific protocols and parent guides on how to facilitate access to community resources. These protocols include a variety of specific interventions that will guide the therapist and parents on how to access these community resources. These protocols and parent guides are used for therapist development as well as in session with the parents and adolescents.

PARENT TRAINING

Therapist works individually with parents as individuals, apart from their parenting role and also to improve their parental functioning. The therapist will help parent with acquisition of skills related to self as well as to parenting practices. The therapist is able to directly address areas that need improvement in communication and parenting practices. The therapist provides opportunities for parent(s) to practice these skills. If therapist feels that the parent will benefit from other services, therapist will make contact with community agency to facilitate process and will follow up with progress throughout the training.

SCHOOL COLLABORATION

Therapist works closely with school personnel to help advocate for the adolescent. The goal is to help adolescent have successful school experiences. The therapist helps the parent become involved in the school by developing positive relationships with the school counselor, teachers, and principal. The therapist uses specific protocols and parent guides on how to facilitate the relationships with school personnel. These protocols include a variety of specific interventions that will guide therapist and parents on how to have a successful outcome with the school. These protocols and parent guides are used for therapist development as well as in session with the parents and adolescents in order to teach them specific skills.

SKILL DEVELOPMENT

Skill development is addressed with the families in many different areas. The therapist addresses skill development with the parents and adolescents individually as well as in family sessions. The therapist will also use community agencies and specific protocols to provide skill development training in different areas. Individually with the parent, the therapist will address skills such as parenting practices, communication skills, anger management, understanding adolescent development, HIV/STD education, and job training. Individually with the adolescent, the therapist will address skills such as anger management, HIV/STD prevention, job training, communication skills, and educational skills.

SUBSTANCE ABUSE/ PREVENTION EDUCATION

The therapist works with the adolescent on addressing drug use. If an adolescent is not using, the focus would be on how the adolescent can stay clean. The therapist helps the adolescent examine how the drug use is impacting his/her life and his/her family. The therapist helps adolescents talk to their parents about their drug use. Also, the therapists work closely with the parents on preparing to listen to their adolescent and helping them in positive ways to stop using drugs or maintain a drug-free living. If a parent is using drugs, the therapist will also work with the parent on addressing his/her own use and how it affects them and his/her adolescent. The therapist will help the parent in his/her own recovery.

THERAPY

The MDFT approach is multidimensional. It works in four areas: the adolescent, the parent, the family, and the extrafamilial (which includes systems outside the family). The model was developed based on the idea that adolescent substance abuse and delinquency are multidimensional problems. Therefore, a multidimensional approach is needed to conceptualize the problems and develop multisystemic interventions to deal with these problems. The therapist is thinking and acting in each of these areas at all times in order to have successful outcomes:

Adolescent—self, family, peer

Parent—self, parenting

Family—healthy family functioning

Extrafamilial—school, neighborhood, legal (juvenile justice, child welfare), social services, medical

OTHER—COURT

The therapist works closely with court officials to help advocate for the adolescent. The goal is to help the parents help their adolescent close his or her current cases and prevent any future arrests. The therapist helps the parent become involved in the court process by developing positive relationships with important court officials, such as the probation officer. The therapist uses specific protocols and parent guides on how to facilitate these relationships with court officials. These protocols include a variety of specific interventions that will guide the therapist and parent on how to have a positive relationship with the courts. These protocols and parent guides are used for therapist development as well as in session with the parents and adolescents in order to teach them specific skills.

OUTCOMES

DECREASES IN SUBSTANCE USE, REDUCTIONS IN NEGATIVE ATTITUDES/BEHAVIORS, IMPROVEMENTS IN POSITIVE ATTITUDES/BEHAVIORS, OTHER TYPES OF OUTCOMES

DECREASES IN SUBSTANCE USE

- 41% to 66% reduction in substance abuse from intake to program completion. Treatment gains were maintained up to 1-year posttreatment
- MDFT reduced the severity of substance-related impairment

At 1-year post-intake:

- 93% of youth receiving MDFT reported no substance-related problems
- 64% to 93% of young adolescents receiving MDFT reported abstinence from alcohol and drug use at 1-year followup

REDUCTIONS IN NEGATIVE ATTITUDES/BEHAVIORS

- MDFT decreased delinquent behavior and affiliation with delinquent peers significantly more than peer group treatment. In addition, MDFT clients were less likely to be arrested or placed on probation than group clients

- MDFT decreased family conflict, improved parenting practices, and improved family functioning to a greater extent than family group therapy or peer group therapy
- MDFT clients showed a significantly greater decrease in disruptive school behaviors and absences than youth receiving comparison treatment

IMPROVEMENTS IN POSITIVE ATTITUDES/BEHAVIORS

MDFT improved school functioning (grades and behavior):

- MDFT clients return to school and receive passing grades at higher rates (43% in MDFT vs. 17% in family group therapy and 7% in peer group therapy)
- MDFT clients also show significantly greater increases in conduct grades than peer group treatment

OTHER TYPES OF OUTCOMES

MDFT costs less than standard treatments:

- Average weekly costs of treatment are significantly less for MDFT ($164) than community-based outpatient treatment ($365)
- Average weekly costs of an intensive version of MDFT, designed as an alternative to residential treatment, costs less. Weekly costs: MDFT—$384; residential substance abuse treatment—$1,068

MDFT effectively engages and retains a range of adolescents in treatment:

- 3-month retention: 95% of clients in intensive outpatient MDFT stayed in treatment for 90 days as compared to 59% in a comparison residential treatment
- 6-month retention and treatment completion: 88% of clients in intensive outpatient MDFT completed treatment (180 days) as compared to 24% in residential treatment
- 96% of early adolescent sample in MDFT completed treatment (120 days), as compared to 78% of youth in group therapy

BENEFITS

MDFT youth:

- Were significantly less likely to use illegal drugs or alcohol
- Significantly reduced a range of psychiatric symptoms
- Significantly reduced their affiliation with antisocial and drug-using peers
- Significantly increased their individual developmental functioning on measures of self-esteem and social skills
- Significantly improved their relationships with parents on self-report and observational measures
- Significantly improved their school functioning

MDFT parents:

- Significantly increased their involvement in their teen's everyday life and improved their relationship with their youth
- Significantly improved their parenting skills and decreased their stress

HOW IT WORKS

MDFT is a three-stage intervention system that has been designed, adapted, and tested in a variety of different versions. It has been applied according the clinical characteristics of the adolescent client group and treatment setting. In all of its versions, MDFT operates from 10 therapeutic principles designed to guide a therapist's overall mindset toward change and, ultimately, making changes at different system levels, in different domains, and with different people inside and outside of the family, on behalf of the treated youth.

Stage 1 includes a comprehensive assessment of problem areas and pockets of untapped or underutilized strength. Strong therapeutic or working relationships are established with all family members and influential persons such as school or juvenile justice personnel. Stage 2 is the working phase of treatment where significant change attempts are made within and across the interlocking subsystems (e.g., individual, family, peers, school, etc.) that are assessed at the outset of treatment. Stage 3 seals the changes and prepares the youth and family for their next stage of development, using the knowledge, experience, and skills gained in the treatment. Each stage includes core work in each of the four MDFT assessment and intervention domains—the individual, the adolescent and parent, the family interaction system, and the extrafamilial social system.

IMPLEMENTATION ESSENTIALS

Information may include staff and administrative support; involvement (community, family, school, etc.); training and technical assistance; program resources and materials; staff-to-program participant ratios (where applicable); space/location and equipment requirements; and implementation timeline.

Minimum of one MDFT team per site. A team is composed of two full-time therapists, one full-time therapist assistant/case manager, and one half-time supervisor. One team can serve small caseloads of five to eight adolescents/families, depending on geographical area served and nature of cases to be seen (e.g., more severe cases require smaller caseloads). MDFT needs a dedicated staff willing to administer home-based intervention, conduct sessions in juvenile justice and school settings, and participate in MDFT training and supervision. Initial training takes approximately 7 months; ongoing supervision after initial training phase is required as well. Each team member must have a cell phone and be reimbursed for calling and travel expenses. Each clinic must have urine test kits and videotaping equipment. Therapists should have master's degrees. Treatment length is 4 to 6 months.

EVALUATION DESIGN

Four kinds of research studies support the effectiveness of the MDFT treatment system. First, clinical effectiveness of MDFT has been demonstrated by several randomized controlled clinical trials. These studies were often conducted in community settings and with master's-level nonresearch clinicians, factors that increase the ability to generalize the results. In these random controlled trials, MDFT was compared to multifamily education therapy and group therapy for teens (n=95 adolescents); group therapy for adolescents (n=83); individual cognitive behavioral therapy (n = 224); MET/CBT5 and the Adolescent Community Reinforcement Approach (ACRA) (n=300); residential treatment (n=113); and in a prevention trial, to a school-based prevention program for high-risk early adolescents (n=124).

A second type of study—process research—has allowed MDFT treatment developers to articulate a wide variety of core aspects of the MDFT therapeutic process, including key features such as the therapeutic alliance (therapist–youth and therapist–parent); strategies to change parenting practices; in-session conflict between parents and youths; and the use of cultural content foci and themes to promote therapeutic participation of youths.

A third type of study involves economic analyses of MDFT relative to standard treatments. These studies have been designed to conduct a thorough analysis of the costs of treatment, evaluate economic benefits of treatment using standard economic methods, and compare the costs and benefits to see if the treatments reduce costs to society. Costs to society are gauged by the impact of treatment on the use of health services, reductions in criminal activity and associated costs (i.e., arrests, detainment, etc.), and increases in school attendance and employment.

And a fourth study type involves the dissemination of MDFT into nonresearch clinical settings. This study involved a multicomponent, multilevel technology transfer intervention developed to train treatment staff to implement MDFT within the structure of an existing day treatment program. Targets of this dissemination effort included therapists' practice patterns, clients' outcomes, as well as broader program factors. Results indicate that MDFT can be successfully transported into a community day treatment program, and that providers continued to deliver MDFT after expert supervision was withdrawn. The implementation of MDFT was shown to have a positive impact on therapist practice patterns, client outcomes, and program environment.

EVALUATION INSTRUMENTS

EVALUATION INSTRUMENTS

For information regarding evaluation instruments please contact:

Dr. Cindy Rowe
Research Assistant Professor
Center for Treatment Research on Adolescent Drug Abuse (CTRADA)
University of Miami School of Medicine
PO Box 019132
Miami, FL 33101
Phone: (305) 243–3653
E-mail: crowe@med.miami.edu

DELIVERY SPECIFICATION

4–6 MONTHS

Amount of time and, if applicable, the number of sessions required to deliver the program and obtain documented outcomes:

MDFT treatment lasts 4 to 6 months.

INTENDED SETTING

URBAN, SUBURBAN

In these settings, MDFT has been implemented with fidelity to the manual and has obtained positive outcomes on a variety of symptoms and prosocial measures with youth 12 to 17 years of age.

FIDELITY

Components that must be included in order to achieve the same outcomes cited by the developer:

- Supervisors trained and skilled in the MDFT approach
- Caseload of no more than six to eight cases per therapist
- Clinical training of therapists in the MDFT program
- Administrative support
- The capacity to do in-home sessions
- Each team member must have a cell phone
- Each team member must be reimbursed for phone and travel expenses, in-home work, and travel time
- Each clinic must have urine test kits
- Each clinic must have videotaping equipment
- Treatment length of 4 to 6 months

List all fidelity instruments and information on where each instrument can be obtained:

- Therapist Behavior Rating Scale (Hogue, Rowe, Liddle, & Turner, 1994; Hogue et al, 1998): Observational rating system of the extensiveness of therapists' use of MDFT-specific and general therapy techniques in sessions.
- MDFT Therapist Competence Scale (Hogue, Liddle, & Becker, 2003): Observational rating system of therapists' competence in delivering MDFT interventions in the four domains as well as other specific aspects of competence.
- Therapist contact log: Therapist self-report of dosage and parameters of interventions delivered in the four domains.

All fidelity instruments are available at Center for Treatment Research on Adolescent Drug Abuse, www.miami.edu/ctrada.

For information regarding fidelity instruments, please contact:

Dr. Cindy Rowe
Research Assistant Professor
Center for Treatment Research on Adolescent Drug Abuse
University of Miami School of Medicine
PO Box 019132
Miami, FL 33101
Phone: (305) 243–3653

E-mail: crowe@med.miami.edu

BARRIERS AND PROBLEMS

Barrier: In the field, most therapists receive insufficient levels of support (preparation and ongoing clinical supervision) to do their work.

Solution: If sufficient will and funds exist in a community, MDFT can be implemented with the same fidelity as during clinical trials.

Barrier: The main barrier is at the stage before a State, a treatment agency or, in some cases, a country, makes the decision to do what it takes to implement an evidence-based program like MDFT.

Solution: Once the upper-level administrators committed to implement MDFT and secured sufficient funds to train personnel and to provide ongoing support for the therapists (e.g., recertification of MDFT credentials), the implementation was successful.

PERSONNEL

FULL-TIME, PART-TIME, PAID

Types of positions needed to successfully implement this Model Program:

A minimum of one MDFT team per site. A team is composed of:

- Two full-time therapists
- One full-time therapist assistant/case manager
- One half-time (50 percent) supervisor

A team will handle small caseloads of five to eight families, depending on geographical area served and nature of the cases seen (e.g., more severe cases or less accessible areas require smaller caseloads). MDFT needs dedicated staff willing to administer home-based intervention, conduct sessions in juvenile justice and school settings, and participate in MDFT training and supervision.

Typical staffing issues encountered by users when implementing this Model Program, and potential solutions: None

EDUCATION

GRADUATE, SPECIAL CERTIFICATION, SPECIAL SKILLS

Education/qualifications of the personnel needed to successfully implement this Model Program:

Master's-level therapists (degree in social work, counseling, or related area)

Master's-level supervisor (clinical supervisor)

PERSONNEL TRAINING

TYPE: SEMINARS/WORKSHOPS, WORKBOOK, LOCATION: ONSITE, OFFSITE, LENGTH: BASIC

Required personnel training, including the type, location, length, and any other requirements:

WORKBOOK, SEMINARS/WORKSHOPS

In addition to working through the MDFT manual, training includes extensive use of video/DVD of actual MDFT therapy and activities and exercises designed to facilitate model adherence and competence.

ONSITE, OFFSITE

Trainings occur at the University of Miami Medical School, Center for Treatment Research on Adolescent Drug Abuse, or onsite at the trainee's location.

BASIC

Initial training takes approximately 7 months; ongoing supervision after the initial training phase is required.

COST

$50,000+

Cost considerations for implementing this program as recommended by the developer:

BUDGET COSTS:

A clinic must have at least one MDFT team consisting of 2 FTE therapists with master's degrees and 1 FTE case manager (bachelor's or associate's degree), plus a 50% time clinical supervisor. Other requirements include: cell phones, videotape equipment, urine test kits, and reimbursement for staff transportation costs.

TRAINING COSTS:

Cost for intensive 6 months of training leading to certification are inclusive; there are no extra fees. Final costs are determined individually, depending on travel costs and other features unique to each trainee organization. Approximate costs are as follows: $35,000 for one team, $60,000 for two teams, and $75,000 for three teams.

MATERIALS COSTS:

There is no cost for materials. The cost of materials is included in the training costs.

INTENDED AGE GROUP

EARLY ADOLESCENT (12–14), TEENAGER (15–17)

MDFT has been used with success with youth 12 to 17 years of age.

INTENDED POPULATION

AFRICAN AMERICAN, HISPANIC/LATINO, WHITE

Populations to which the Model Program was delivered include:

Study 1—18% African American, 15% Hispanic/Latino, 51% White non-Hispanic, 6% Asian, 10% Other

Study 2—72% African American, 10% Hispanic/Latino, 13% White non-Hispanic

Study 3—47% African American, 47% White non-Hispanic, 6% Other

Study 4—42% Hispanic/Latino, 38% African American, 20% Other

Study 5—69% Hispanic/Latino, 31% Other

Study 6—70% Hispanic/Latino, 25% African American, 5% White non-Hispanic

These studies generally included youth and families from poor socioeconomic circumstances, but also included youth and families from more working-class communities as well.

MDFT currently is being implemented with American Indian youth in Oklahoma and in six European countries; Belgium, France, Germany, The Netherlands, Scotland, and Switzerland.

GENDER FOCUS

BOTH GENDERS

MDFT is successful with both genders.

DEVELOPER INFORMATION

ABOUT THE DEVELOPER:

Howard A. Liddle, Ed.D., ABPP, is an internationally recognized expert on family-based treatment for adolescent substance abuse and delinquency. A psychologist and diplomat in the American Board of Professional Psychology, Dr. Liddle is a professor in the Departments of Epidemiology and Public Health, Psychology, and Counseling Psychology at the University of Miami School of Medicine. He also is Director of the Center for Treatment Research on Adolescent Drug Abuse at the University of Miami School of Medicine. His 25 years of work in the adolescent substance abuse have garnered career achievement awards from the American Psychological Association, the American Association for Marriage and Family Therapy, and the American Family Therapy Academy. He also was the recipient of the 2003 Dan Anderson Research Award from the Hazelden Foundation.

REPLICATIONS

1. BRIEF DESCRIPTION

MDFT was implemented in four sites in the State of Connecticut, offered as an alternative to residential substance abuse treatment. Implementing the most intensive version of MDFT (5–6 months of treatment with caseloads of six cases per therapist). No known differences between this replication and the developer implementation, but no adherence and competence data have been collected.

2. REPLICATION SETTING

Four sites in the State of Connecticut.

3. REPLICATION SITE

Replications were effected through Wheeler Clinic, a community-based treatment agency, using intensive in-home programs.

PBC
91 Northwest Drive
Plainville, CT 06062
Contact: Jennifer Barnett
Phone: (860) 793–4413

The Village for Families and Children
Dr. Isaiah Clark Family & Youth Clinic
2550 Main Street
Hartford, CT 06106
Contact: Catherine Corto-Mergins
Phone: (860) 527–4224

Hartford Behavioral Health (HBH)
2550 Main Street
Hartford, CT 06120
Contact: Vanessa Pagan
Phone: (860) 727–8703

Child Guidance of Southern Connecticut
103 West Broad Street
Stamford, CT 06902
Contact: Dr. Larry Rosenberg
Phone: (203) 324–6127

4. CONTACT INFORMATION

Dr. Reginald Simmons
State of Connecticut Department of Children and Families
Bureau of Behavioral Health, Medicine and Education
505 Hudson Street
Hartford, CT 06106–7107
Phone: (860) 560–5087 or (860) 566–8022
E-mail: REGINALD.SIMMONS@po.state.ct.us

ADAPTIONS

1. NATURE OF THE ADAPTATION

MDFT was implemented in clinical sites in five countries in Europe as part of the five-country **Action Plan for Cannabis Research (APCR)**, including Belgium, France, Germany, The Netherlands, and Switzerland. The APCR prioritized the need for an effective treatment for cannabis dependence in multiproblem youth in Western Europe, and chose MDFT based on a systematic review of the drug treatment literature.

The five countries supporting the APCR decided to carry out a pilot study to assess the feasibility of MDFT implementation in Western Europe. The European MDFT project is called **INCANT** (INternational CAnnabis Need of Treatment). Therapists in each country were trained by expert MDFT trainers over a period of 6 months and delivered the model with three pilot cases each.

2. SUMMARY DESCRIPTION

Few adaptations to the MDFT model were needed, despite the wide variation in clinical settings and cases. Most of the modifications that were needed had to do with the extent and nature of "extrafamilial interventions"—the ways in which therapists worked with systems such as school and court. Core MDFT principles and techniques were delivered with adequate adherence and competence as rated on the TBRS and Therapist Competence Scale.

3. ADAPTATION SITE AND SETTING

To determine the feasibility of MDFT in Western Europe, each country created an MDFT team composed of one supervisor and two to four therapists from one or more nearby centers. Participating centers varied from hospital-based addiction units to juvenile justice programs. All programs treated substance-abusing youth on an outpatient basis. The programs were: (a) Belgium: Cannabis Clinic and Rimbaud Unit, Brugmann Hospital, Brussels; (b) France: Centre Emergence and CEDAT Mantes la Jolie, Paris; (c) Germany: Therapieladen, Berlin; (d) The Netherlands: Parnassia-Mistral and Palmhuis, The Hague; and (e) Switzerland: Jugendberatung der Stadt Zürich, Drop In (Basel), and CONTACT (Bern).

4. CONTACT INFORMATION

Dr. Henk Rigter
Erasmus University
The Hague, Netherlands
Viviënstraat 24
2582 RT, The Hague
The Netherlands
Phone: 31–70–3522090
E-mail: h.rigter@erasmusmc.nl

ADAPTIONS

1. NATURE OF THE ADAPTATION

Substances-abusing juvenile offenders are an extremely high-risk group for acquiring HIV/AIDS and other sexually transmitted diseases (STDs). The MDFT HIV intervention is vitally important because it provides education regarding HIV and other STDs not only to adolescents, but also to their parents. The MDFT HIV intervention includes working with adolescents and parents individually and as a family in sessions. Also, the therapist works in collaboration with community agencies to provide educational workshops to the adolescents and to provide adolescents with HIV and STD testing.

2. SUMMARY DESCRIPTION

The MDFT program was adapted by adding the HIV/STD education component to the therapeutic work in each domain. The HIV intervention has four components: adolescent, parent, community, and family. Each component includes psychoeducation about STDs and HIV, and support; increased communication about STDs; and HIV between adolescents and parents.

The adolescent component includes videos, games, role-playing, and discussions. This component is implemented during treatment sessions in collaboration with the workshops conducted by Care Resources.

The community component includes taking adolescents for HIV/STD testing at community health agencies. Also, the adolescent participates in a community service component that involves educating others about HIV/STD.

The parent component includes discussions with therapist and preparation to talk to their adolescents about sex.

In the family component, the therapist helps the adolescent talk to their parents about what they have learned, and this will open the door for the family to talk about sex honestly. The family will make a pact to have regular discussions regarding the adolescent's questions or concerns about sex. By increasing the communication between the adolescent and the parents about sex, the parent is able to influence the adolescent regarding sexual behavior and protect him or her from contracting STDs or HIV.

3. ADAPTATION SITE AND SETTING

The adapted MDFT program, including the HIV Intervention, was implemented in the clients' homes in urban Dade County, Florida.The workshop component, provided by Care Resources, was conducted at the University of Miami Center for Treatment Research on Adolescent Substance Abuse. HIV and STD testing was provided by the health centers in the Miami-Dade County area, such as Adolescent Medicine at University of Miami/Jackson Memorial Hospital and Center for Haitian Studies.

4. CONTACT INFORMATION

University of Miami
Center for Treatment Research on Adolescent Drug Abuse
University of Miami School of Medicine
1400 NW 10th Avenue, Suite 1108 Dominion Tower
Miami, FL 33156 USA
Phone: (305) 243–6434

Care Resources
Contact: Tony Martinez
Phone: (305) 576–1234, ext. 291

Community Health Centers
Adolescent Medicine
Phone: (305) 243–5880

Center for Haitian Studies
Phone: (305) 757–9555

CONTACT INFORMATION

FOR PROGRAM INFORMATION, CONTACT

Gayle A. Dakof, Ph.D.
Center for Treatment Research on Adolescent Drug Abuse
University of Miami School of Medicine
1400 NW 10th Avenue, Suite 1108 Dominion Tower
Miami, FL 33156 USA
Phone: (305) 243–5327
E-mail: gdakof@med.miami.edu